Exhibit A

(Insert Employing Organization's Letterhead Here)

EMPLOYEE ACKNOWLEDGEMENT

(Must be signed and returned to Human Resources Office no later than_____)

I, _____(Name)_____acknowledge receipt of my employer's letter of _____(Date)_____ instructing me to file a Short Term Disability (STD) claim with The Hartford **no later than my fifteenth (15th) calendar day of absence from work (or as soon as reasonably possible).** Enclosed with the letter, I received an "Employee STD Claim Filing Checklist/Guidelines & Activity Log" with step-by-step information on: My responsibilities; important timeframes and action items; filing my STD claim; what to expect from my employing organization; and receiving assistance to stay at work or return to work.

I agree that I will file an STD claim with The Hartford as instructed by my employer and acknowledge that I am *ineligible* to utilize paid available leave in lieu of filing an STD claim with The Hartford.

I acknowledge that it is my responsibility to promptly notify and repay the State of Delaware overpaid STD wages in full as a result of a current or retroactive "Other Income Benefits" award (i.e., Workers' Compensation, Social Security Disability, etc.,) defined in Section 8.6 and 16.5 of the Disability Rules & Regulations posted on SBO's website at www.ben.omb.delaware.gov/disability. If awarded Long Term Disability (LTD) benefits, in some cases The Hartford may directly pay to the State of Delaware LTD payments that it would otherwise pay to you until the State of Delaware has been paid in full for overpaid STD wages. Failure to repay overpaid STD wages in full may lead to a loss of earnings and/or disciplinary action.

Employee's Name_____

Employee's Signature_____

Date_____